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INTENTIONAL VIOLENCE (S BONNE, SECTION EDITOR)

Violence in the Elderly: a Review of the Literature

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Abstract

Purpose of Review Violence targeting elder adults is a pervasive problem. Given the anticipated growth of this age demographic, addressing violence will become even more imperative and better solutions needed.

Recent Findings A PubMed search of the literature was performed to identify relevant articles addressing violence in the elderly. The search was limited to articles published within the last 10 years, with greater emphasis on those written within the past 5 years. Whether it be self-directed, perpetrated by older adults against others, or specifically directed towards older adults, violence in the elderly carries with it many negative repercussions. Among the factors reportedly associated with elder abuse are age, female gender, lower socioeconomic status, marital status, location of residence, and health status.

Summary Increasing the focus on violence is critical. Integrated approaches at multiple levels are essential in improving identification, intervention, and prevention strategies among people at risk for perpetrating or becoming victims of violence.

Introduction

Violence, either domestic or collective, can affect all age groups and can remain present throughout the lifespan. Violence focused towards individuals over the age of 65 is a pervasive problem and can present itself in several forms [1, 2, 3]. Whether it be self-directed, perpetrated by older adults against others, or specifically directed towards older adults, [3, 4] violence in the elderly carries with it many negative repercussions. These include, but are not limited to, worse mental health outcomes, diminished quality of life, higher rates of homicide or suicide, and increased healthcare costs [4–8]. Across all forms of violence, access to firearms increases lethality and veterans may be at particularly high-risk [6, 9] and the impact can be detrimental. The number of firearms in the USA exceeds 27 million [9] and remains the focus of many current legislative and legal battles which is beyond the scope of this review.

The Centers for Disease Control and Prevention (CDC) reported that more than 643,000 older adults were treated in the emergency department (ED) for nonfatal assaults from 2002 to 2016 [3]. However alarming that number may seem, it's important to be cognizant that this is likely a gross underestimation as data only captures those individuals treated in the ED and documented in such a way for this data to be identified. It is estimated that for each reported case of elder victimization, five more cases go unreported [10]. Older adults may be more susceptible to violence and abuse due to mental, physical, and social influences. The differing forms of violence may also have some common risk factors, and older adults may be targeted specifically due to their perceived vulnerability. They may also have specific challenges for prevention, such as balancing autonomy and well-being in vulnerable adults. [4]

The anticipated growth of the US population ages 65, and older is expected to double to 88.5 million by 2050 [11]. Given this explosive projection, addressing violence and abuse against the elderly will become even more imperative and better solutions needed. While the psychological impact of violence is clearly established in working age adults, less is known about the nature and impact of violence among older adults. The physical, emotional, and cognitive limitations that may present themselves in the aging population may lead to greater dependence and susceptibility of this population to violence and maltreatment [5]. The following

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review provides an overview of the scope of the problem, risk factors, characteristics of perpetrators, and key aspects of prevention.

Materials/Methods

A PubMed search of the medical literature was performed to identify all relevant articles on violence in the elderly. The search was limited to articles published within the last 10 years, with greater emphasis on those written within the past 5 years. The main keywords searched were "violence in the elderly," "elder maltreatment," "prevention of violence," "risk factors AND violence in the elderly," "types of violence and abuse," and "implications of violence in the elderly." Articles were screened on the basis of their importance, quality, number of patients, and relevance of the aims of the review. These were further limited by those with full text available, systemic reviews, and meta-analysis and those written or translated into the English language.

Results

Types of Violence

The World Health Organization (WHO) distinguishes four modes in which abuse may be inflicted onto others; these consist of deprivation, sexual, psychological, and physical (violence) abuse [2]. The general definition of violence can be divided into different subtypes according to the relationship between the victim and the perpetrator relationship. *Self-directed violence* encompasses suicide or nonfatal self-harm. The suicide rates of among the elderly have increased in the past decade, from 35.6/100,000 persons in 2009 to 39.9/100,000 persons in 2018 [12]. Compared with women, men have higher rates of both nonfatal assaults and homicides [3]. The rate of nonfatal assaults has increased more than 75% among men and more than 35% among women in the last 15 years, with the estimated homicide rate for men having increased an additional 7% [3]. *Collective violence* refers to violence committed by larger groups of individuals and can be subdivided into social, political, and economic violence [2]. The true effect of collective violence on the health of the *elderly* has been poorly studied, though it has been suggested that that some geriatric ailments, such as disability, weight loss, falls, depressive symptoms, and low positive affectivity, could be present or worsen in a *violent* environment [13] *Interpersonal violence*, or violence between individuals, is one of the more commonly identified forms of violence. Interpersonal violence is directed towards older adults in the manner of physical, sexual, or intimate partner violence and demonstrates varying levels of prevalence across the globe [1, 14–16]. Interpersonal violence will be the primary focus of the remaining report.

Risk Factors

Among the factors reportedly associated with elder abuse are age, female gender, lower socioeconomic status, marital status, and health status [17–20]. A 2014 analysis by the Bureau of Justice statistics revealed that elderly persons who were divorced or separated (10–8-19.6 per 1,000 persons, respectively) were more likely to be victimized than those who were married.] [21] That same report revealed that, among elderly violent crime victims, about 59% reported being victimized near their place of residence. Residential location also appears to play a role. According a recent analysis by the US Census Bureau, 13.8% of the urban population is 65 years and older [22]. This is especially relevant as elderly victims of violent and property crimes more often resided in urban areas (5.1 per 1,000 persons aged 65 and older) versus rural and suburban areas (2.8–3.2/1000 persons 65 and older, respectively) [21]. Recent data suggests that approximately 17.5% of the rural population is 65 years and older [22]. The lower number of reported crimes against elderly victims in rural areas may be due to challenges in the methods of reporting, as it may be harder to obtain assistance in law enforcement in those areas.

A 2016 analysis by Knight et al. estimated the lifetime prevalence for violence against women over the age of 65 is between 20 and 30% [23]. These findings are not limited to the USA, and several retrospective reviews have attempted to illustrates their own population rates (Table 1). A cross-sectional study addressing domestic violence in Latin America reported physical violence ranging from 2.2 to 18.3% in older men and women [24]. With prevalence ratios ranging from

Table 1 Rates of interpersonal violence in older adults

Reference	N	Physical violence	Sexual violence	Psychological violence
Paiva et al. 2015 [25]	729	5.9%	-	20.9%
Yon et al. 2017 [26]	-	1.9	2.2	11.8
Maia et al. 2019 [1]	178	6%	3%	19%
Gürsoy et al. 2020[27]	367	4.1%	2.5%	23.5%
World Health Organization [2]	-	2.6–14.1%	0.9–1.9%	11.6–33.4%

1.60 to 2.14, elder women were identified as more likely have experienced current or previous episodes of violence [24]. In addition to physical violence, almost half of the participants reported suffering psychological violence at some time during their life. [24] In 2014, Dong et al. identified psychological abuse as the most common form of abuse among older adults, with prevalence ranging from 27.9 to 62.3%. [17].

Older adults may be targeted for violent acts due to their perceived vulnerability and cognitive impairment, namely in the form of dementia. Physical abuse is estimated to affect 3.5–23.1% of older adults with dementia;[17] though again, this is likely an underestimation of the true number of events due to the inherent limitations in the ability for the victim to report these acts of violence. Many older adults experienced multiple forms of abuse simultaneously, and the risk of mortality from abuse and self-neglect was thought to be higher in older adults with greater levels of cognitive impairment. Many victims suffer physical injuries; some may be perceived as minor, like cuts, scratches, bruises, and welts. Others are more serious and can cause lasting disabilities. These include head injuries, broken bones, constant physical pain, and soreness. Physical injuries can also lead to premature death and worsening health problems. [3]

Perpetrators

Efforts have been employed not just to identify at risk individuals for violence, but have also attempted to identify the perpetrators of these heinous acts. It has been well documented that a substantial portion of elder violence is committed by a perpetrator known to the individual, with law enforcement data reporting that only 43% of violent victimizations against the elderly were committed by strangers [21]. Acts of violence include abuse of a dependent older adult by a caregiver as well as incidents involving an independent older adult. [2] Physical abuse in institutional settings are estimated to be much higher than in community settings (14.1% vs 2.6%)[2, 26, 28, 29] with the assailant being familiar to the victim in some form. Though again, this data is limited as it only captures those acts that are reported. Shame, guilt, and/or fear of retribution are likely to be some of the psychological reasons of underreporting.

Opportunities for Improvement

When assessing an elder individual in a health setting, a systematic way to identify whether an individual is experiencing targeted acts of violence remains key. One of the more common locations is the doctor's office or emergency room. If possible, speaking to the elder individual alone (and away from a caregiver) may help illuminate whether he/she feels safe in his/her current environment. The ED assessment should include close observation of patient-caregiver interaction, a comprehensive medical history, and finally, a head-to-toe physical examination. Formal screening protocols may also be useful [16]. New onset bruising, weight loss, sudden decline in previously well controlled health conditions, and increasing depression can also serve as potential signs of abuse/violence. Among five geriatric health problems, weight loss is speculated to display the strongest association with violence [23]. In 2017, García-Peña et al. demonstrated weight loss, disability, and low positive affectivity to be associated with an increased level of collective violence [13]. Hypervigilance from caregivers or visiting family members is pivotal in identification these potentially more subtle signs of abuse (Table 2).

Discussion

Violence can affect any gender or age group and remains prevalent throughout the lifespan. It can exist in wealthy vs impoverished regions as well as developed or underdeveloped countries. No individual or group is immune. As the most rapidly growing segment of the population, older adults may be at particularly high risk and targeted for violent acts due to their perceived vulnerability as well as potential for isolation. As demonstrated in this review, female gender, marital status, and location of residence [21, 22, 30] were identified as risk factors for abuse. Among older adults, interpersonal violence was strongly associated with physical and mental health problems, and the scarce research comparing the impact of interpersonal violence across the age groups suggests that the physical health of older victims may be more severely affected

Table 2 Identifying ways to identify and assist elder adults*

- Listen to older adults and their caregivers to understand their unique challenges
- Report abuse or suspected abuse to Adult Protective Services
- Identify risk factors of elder abuse
- Check-in often on older adults who may be more isolated (few friends and/or family members)
- Provide over-burdened caregivers with support:
- help from friends, family, or local relief care groups adult day care programs counseling
- Encourage and assist persons (either caregivers or older adults) having problems with drug or alcohol abuse

*Adapted from the Centers of Disease Control and Prevention

than younger victims [23]. Though physical violence is suggested to decrease with age, the rates of psychological violence appear to be stable over the lifespan. It also appears to be highest in women.[23,28].

Forms of violence in older adults have some common risk factors, such as medical, physical or cognitive dysfunctions, and common challenges for prevention. Among the five geriatric health problems, weight loss had the strongest association with violence [13]. Pre-existing cognitive impairment/dementia was also identified as a risk factor for abuse and violence, and, not surprisingly, those individuals in this group experiencing violence appear to have worse overall outcomes [17]. Many older adults require care and are vulnerable to violence. Sadly, perpetrators are commonly known to the victim, often in the form of family member or caretaker [2–4, 26, 28, 29] or those in a position or trust. The identification of interpersonal violence is poor among older adults, with limited options for referral and support.

In the USA, the elderly population is growing faster than are younger (< 18 years old) generations [31]. Given the anticipated explosive growth, addressing violence and abuse against the elderly will become even more imperative in the not so distant future. The integration of prevention strategies across the life span, disciplines, and forms of violence offers promise for promoting improved older adult quality of life and well-being. Governmental programs have been developed to help combat the abuse and exploitation of elder adults; these include Adult Protective Services (APS) and the implementation of mandatory elder abuse reporting. With the understanding that physical abuse in institutional settings is higher than in community setting, the Long-Term Care (LTC) Ombudsman program was also developed to help resolve problems related to the health, safety, welfare, and rights of individuals who live in LTC facilities, such as nursing homes, board and care and assisted living facilities, and other residential care communities [32]. Political policies such as The Older Americans Act, the Elder Justice Act, and the National Alzheimer's Project Act have been put in place to help protect this vulnerable segment of the population, and balancing elder autonomy and well-being in vulnerable adults remains an important consideration. Despite the recent increase in research and policy developments surrounding elder abuse, challenges such as insufficient funding, limited knowledge about elder abuse, ambiguity in definitions, a lack of implementation of federal and state programs relevant to elder abuse and dementia, and a lack of dementia-specific training for frontline healthcare staff continues to persist [17]. Better understanding, increased support from our legislators and stronger social programs are still desperately needed. Looking ahead, key areas to address include raising awareness and prioritizing funding for the implementation and evaluation of violence prevention interventions in healthcare settings and the community.

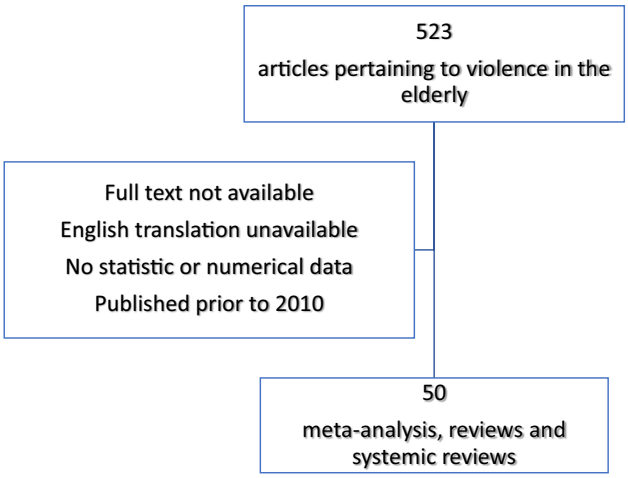

Fig. 1 Flow chart for selection of review articles

Conclusion

Increasing the focus on violence in older adults is critical to addressing this rapidly escalating problem. Integrated approaches at multiple levels are needed to improve identification, intervention, and prevention among people at risk for perpetrating or becoming victims of violence. Attention to firearm access and other risks among vulnerable groups, including veterans, is important to reducing violence and associated harm among older adults Fig. 1.

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Compliance with Ethical Standards

Conflict of Interest Astrid Botty van den Bruele and Marie Crandall declare that they have no conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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